Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

Utah Department of Health Division of Health Care Financing Bureau of Long Term Care

Submission Date:	March 28, 2006

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:
This is a request for renewal of the Physical Disabilities Waiver.

Application for a §1915(c) Home and Community-Based Services Waiver

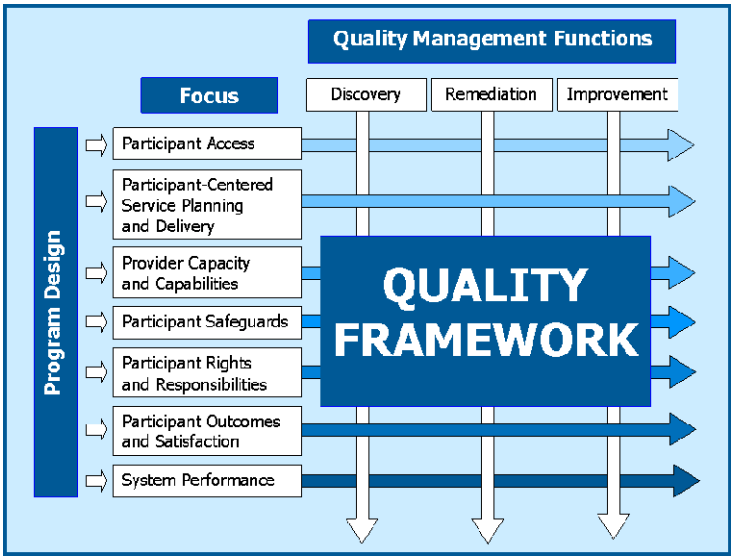
PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*



The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.

State:	
Effective Date	

1. Request Information

A. The **State** of **Utah** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*): Physical Disabilities Waiver

C. Type of Request *(select only one)*:

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #** CMS-Assigned Waiver Number (*CMS Use*): *Attachment #1 contains the transition plan to the new waiver.*		
✓	**Renewal (5 Years) of Waiver #**	0331.90.R1	
○	**Amendment to Waiver #**		

D. Type of Waiver *(select only one)*:

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
✓	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: July 1, 2006

E.2 Approved Effective Date *(CMS Use):*

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	○	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
✓	Nursing Facility *(select applicable level of care)*	
	✓	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
		Not Applicable
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
☐	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:	

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
✓	Not applicable			

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

This waiver provides services and supports for people with significant physical disabilities living in the community. It is designed to be consistent with a service delivery system that promotes and supports participant self determination, maintains a high standard of quality in services and supports and maximizes the distribution and utilization of public funds, both state and federal. The State Medicaid Agency (SMA) has entered into an interagency agreement for the day-to-day administration and operation of this waiver with the State Department of Human Services, Division of People with Disabilities. The SMA retains final administrative authority over the waiver program.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. **Appendix A** specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

✓	The waiver provides for participant direction of services. *Appendix E is required.*
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. **Appendix H** contains the Quality Management Strategy for this waiver.

I. Financial Accountability. **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

✓	Yes
○	No
○	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
✓	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant-Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The Division of Health Care Financing, the State Medicaid Agency (SMA) in collaboration with the division of Services for People with Disabilities, the waiver operating agency, convened a workgroup consisting of current waiver participants, advocates, the Department of Health's Indian Health Liaison, and State stakeholders. The workgroup meetings began in late November 2005 and were open to the public. The workgroup provided the public with the opportunity to give feedback and engage in discussions with the SMA about the proposed waiver renewal application. The workgroup participated in a series of meetings through mid-January.

During the month of February, the draft waiver renewal application was disseminated for broad public input. Public input on the waiver application was compiled for review by the State Medicaid Director for his consideration.

During the development of the waiver renewal application, the SMA met with the Utah Indian Health Advisory Board beginning in December 2005 to describe and seek input into the renewal process and to provide ongoing status reports and consultation throughout the renewal process.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Tonya
Last Name	Keller
Title:	Director, Bureau of Long Term Care
Agency:	Utah Department of Health, Division of Health Care Financing
Address 1:	PO Box 143101
Address 2:	
City	SLC
State	UT
Zip Code	84114-3101
Telephone:	(801)538-9136
E-mail	tkeller@utah.gov
Fax Number	(801)538-6412

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	George
Last Name	Kelner
Title:	Director, Division of Services for People with Disabilities

Agency:	Utah Department of Human Services
Address 1:	120 N 200 W #411
Address 2	
City	SLC
State	UT
Zip Code	84103
Telephone:	(801)538-4208
E-mail	GKELNER@utah.gov
Fax Number	

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:**

State Medicaid Director or Designee

First Name:	Michael
Last Name	Hales
Title:	Director, Division of Health Care Financing
Agency:	Utah Department of Health
Address 1:	PO Box 143101
Address 2:	
City	SLC
State	UT
Zip Code	84114-3101
Telephone:	(801)538-6965
E-mail	mthales@utah.gov
Fax Number	

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

○	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):
	○ The Medical Assistance Unit *(name of unit)*:
	○ Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)
✓	The waiver is operated by **Division of Services for People with Disabilities (DSPD)** a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *Complete item A-2.*

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

INTERAGENCY AGREEMENT FOR OPERATIONS AND ADMINISTRATION OF THE HCBS WAIVER

An interagency agreement between the State Medicaid Agency and DSPD sets forth the respective responsibilities for the administration and operation of this waiver. The agreement delineates the State Medicaid Agency's overall responsibility to provide management and oversight of the waiver including review and approval of all waiver related rules and policies to ensure compliance with Medicaid HCBS Waiver rules and regulations. The agreement also delineates DSPD's roles in relation to the statutory responsibilities to develop the State's program for persons with disabilities. The nature of the agreement enhances provider access to the Medicaid program and quality assurance of services as well as defines the fiscal relationship between the two agencies.

The major components of the agreement are:

1. Purpose and Scope;
2. Authority;
3. Definitions;
4. Waiver Program Administration and Operation Responsibilities;
5. Claims Processing;
6. Payment for Delegated Administrative Duties (including provisions for State match transfer);

7. Role Accountability and FFP Disallowances; and
8. Coordination of DHS Policy Development as it Relates to Implementation of the Medicaid Program.

The SMA monitors all aspects of the interagency agreement through a series of quality assurance activities, ongoing technical assistance, reviews and approves all rules, regulations and policies that govern waiver operations. There is a formal program review conducted annually by the Quality Assurance Team. One aspect of this review is to determine compliance with the agreement. If ongoing or formal annual reviews conducted by the Quality Assurance Team reveal concerns with compliance DSPD is required to develop plans of correction within specific time frames to correct the problems. The Quality Assurance Team conducts follow up activities to ensure that corrections are sustaining.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (s*elect one)*:

○	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
✓	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(check each that applies)*:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*
☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
✓	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	✓	✓	☐	☐
Assist individuals in waiver enrollment	☐	✓	☐	☐
Manage waiver enrollment against approved limits	☐	✓	☐	☐
Monitor waiver expenditures against approved levels	✓	✓	☐	☐
Conduct level of care evaluation activities	☐	✓	☐	☐
Review participant service plans to ensure that waiver requirements are met	☐	✓	☐	☐
Perform prior authorization of waiver services	☐	✓	☐	☐
Conduct utilization management functions	☐	✓	☐	☐
Recruit providers	☐	✓	☐	☐
Execute the Medicaid provider agreement	✓	☐	☐	☐
Determine waiver payment amounts or rates	✓	✓	☐	☐
Conduct training and technical assistance concerning waiver requirements	✓	✓	☐	☐

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
○	**Aged or Disabled, or Both**			
☐	Aged (age 65 and older)			☐
✓	Disabled (Physical) (under age 65)			
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both**			
☐	Autism			☐
☐	Developmental Disability			☐
☐	Mental Retardation			☐
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

b. Additional Criteria. The State further specifies its target group(s) as follows:

The individual must:

1. Meet admission criteria for Nursing Facility (NF) care in accordance with UAC R414-502-3.
2. Have established programmatic eligibility through the Utah Department of Human Services for state matching funds in accordance with Title 62A-Chapter 5-Part 1 and UAC R539-1-6 by meeting the following criteria:

- Have at least one personal attendant trained (or willing to be trained) and available to provide the authorized waiver services in a residence that is safe and can accommodate the personnel and equipment (if any) needed to adequately and safely care for the individual. The operating agency will provide information to the individual about potential community resources to assist them in recruiting an attendant.
- Be medically stable, have a physical disability and require in accordance with his/her physician's written documentation, at least 14 hours per week of personal assistance services (as described in appendix B of this waiver) in order to remain in the community and prevent unwanted institutionalization. For purposes of this waiver, the individual's qualifying disability and need for personal assistance services are attested to by a medically

determinable physical impairment which the physician will expect to last for a continuous period of not less than 12 months and which has resulted in the individual's functional loss of two or more limbs, to the extent that the assistance of another trained person(s) is required in order to accomplish activities of daily living/instrumental activities of daily living.

- Have decision making capability, as certified by his/her physician, of selecting, training and supervising her/his own attendant(s).*
- Have decision making capability of managing the individual's own financial and legal affairs.
- Be a resident of Utah.

* Individual's possessing decision making capability, but having communication deficits or limited English proficiency may select a representative to communicate decisions on the individual's behalf.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

✓	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

- ✓ **No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.* The limit specified by the State is *(select one)*:
  - ○ _____ %, a level higher than 100% of the institutional average
  - ○ Other *(specify)*:
- ○ **Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ○ **Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.*

  The cost limit specified by the State is *(select one)*:
  - ○ The following dollar amount: $ _____

    The dollar amount *(select one)*:
    - ○ Is adjusted each year that the waiver is in effect by applying the following formula:
    - ○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.
  - ○ The following percentage that is less than 100% of the institutional average: _____ %
  - ○ Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
☐	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
☐	Other safeguard(s) *(specify)*:

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	150
Year 2	150
Year 3	150
Year 4 (renewal only)	150
Year 5 (renewal only)	150

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

✓	The State does not limit the number of participants that it serves at any point in time during a waiver year.
○	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

✓	**Not applicable**. The state does not reserve capacity.
○	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

✓	The waiver is not subject to a phase-in or a phase-out schedule.
○	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

✓	Waiver capacity is allocated/managed on a statewide basis.
○	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

A. Medicaid recipients who meet the programmatic eligibility requirements as defined in Appendix B-1: 1b for the Physical Disabilities Waiver may choose to receive services in a NF or

through the Physical Disabilities Waiver. If available capacity exists individuals are given the opportunity to choose to receive services to meet the identified needs through a NF or enter the Physical Disabilities Waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the individual record.

B. If no available capacity exists in the Physical Disabilities Waiver, the applicant will be advised in writing that he or she may access services through a NF or may wait for open capacity to develop in the Physical Disabilities Waiver. If the individual chooses to wait for open capacity the operating agency provides information about community resources to assist the individual. In addition, if the individual is currently Medicaid eligible, they have access to Medicaid State Plan services.

The State has developed policies prioritizing access to individuals waiting for waiver services. These policies provide opportunities for access to individuals residing in the community and in institutional settings.

The DSPD has established a Critical Needs Assessment process by which individuals are ranked to prioritize access to waiver services. A significant component of the Critical Needs Assessment tool addresses the immediacy of the need for services and the individual's risk in not gaining access to waiver services.

Individuals in nursing facilities do not demonstrate an immediate need for services, nor do they present as being at high risk if waiver services are not extended to them, individuals in institutional facilities rank extremely low on the prioritization for receipt of waiver services.

The State recognized this problem and initiated a separate process in which individuals in institutional settings may gain access to waiver services. Medicaid recipients residing in nursing facilities, meeting the Physical Disabilities Waiver criteria may gain access to the waiver by having the State general funds that supported the person in the nursing facility follow the person into the Physical Disabilities waiver, the money-follow-the-person concept.

The State believes the existence of these two access points of admission into the waiver is an equitable methodology to support access from both the institution and the community. This methodology is supported by the State's Olmstead Advisory Committee and has not resulted in growth of the NF program. The State has chosen to not reserve capacity to accommodate both points of entry and will amend the waiver if necessary.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

○	§1634 State
✓	SSI Criteria State
○	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)			
☐	Low income families with children as provided in §1931 of the Act		
✓	SSI recipients		
☐	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121		
✓	Optional State supplement recipients		
✓	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*		
	✓	100% of the Federal poverty level (FPL)	
	○	%	of FPL, which is lower than 100% of FPL
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)		
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)		
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)		
✓	Medically needy		
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:		
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*			
○	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.		
○	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*		
	○	All individuals in the special home and community-based waiver group under 42 CFR §435.217	

	✓	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:				
		✓	A special income level equal to (select one):			
			✓	300% of the SSI Federal Benefit Rate (FBR)		
			○	%	of FBR, which is lower than 300% (42 CFR §435.236)	
			○	$	which is lower than 300%	
		☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)			
		☐	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)			
		☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)			
		☐	Aged and disabled individuals who have income at: *(select one)*			
			○	100% of FPL		
			○	%	of FPL, which is lower than 100%	
		☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) *specify*:			

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

✓	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
○	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
✓	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
○	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
✓	The following standard included under the State plan *(select one)*			
○	SSI standard			
○	Optional State supplement standard			
○	Medically needy income standard			
✓	The special income level for institutionalized persons *(select one):*			
✓	300% of the SSI Federal Benefit Rate (FBR)			
○	%	of the FBR, which is less than 300%		
○	$	which is less than 300%.		
○	%	of the Federal poverty level		
○	Other (specify):			
○	The following dollar amount:	$	If this amount changes, this item will be revised.	

○	The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
✓	Not applicable *(see instructions)*		

iii. Allowance for the family *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		
✓	Not applicable (see instructions)		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
    - [ ]
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ [ ] % of the FBR, which is less than 300%
    - ○ $ [ ] which is less than 300% of the FBR
  - ○ [ ] % of the Federal poverty level
  - ○ Other (specify):
    - [ ]
- ○ The following dollar amount: $ [ ] If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:
  - [ ]

ii. Allowance for the spouse only (*select one*):

- ○ The following standard under 42 CFR §435.121
  - [ ]
- ○ Optional State supplement standard
- ○ Medically needy income standard
- ○ The following dollar amount: $ [ ] If this amount changes, this item will be revised.
- ○ The amount is determined using the following formula:
  - [ ]
- ○ Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

- ○ AFDC need standard
- ○ Medically needy income standard

○	The following dollar amount: $ [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the State plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ ____ % of the FBR, which is less than 300%
    - ○ $ ____ which is less than 300%.
  - ○ ____ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

  Specify the amount of the allowance:
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
  - ○ The amount is determined using the following formula:
- ○ Not applicable

iii. Allowance for the family *(select one)*:

○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ ____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○	The following standard included under the State plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	

	○	Other (specify):	
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		

ii. <u>Allowance for the spouse only</u> (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	○	The following standard under 42 CFR §435.121:	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount:	$ If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
○	Not applicable		

iii. <u>Allowance for the family</u> *(select one)*

○	AFDC need standard	
○	Medically needy income standard	
○	The following dollar amount: $	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:	
○	Other (specify):	
○	Not applicable (see instructions)	

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
○	Other (*specify*)**:**		

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*	
○	Allowance is the same
○	Allowance is different. Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:
a. Health insurance premiums, deductibles and co-insurance charges.
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):*	
	One	
ii.	**Frequency of services**. The State requires *(select one)*:	
	✓	The provision of waiver services at least monthly
	○	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	Directly by the Medicaid agency
✓	By the operating agency specified in Appendix A
○	By an entity under contract with the Medicaid agency. *Specify the entity*:
○	Other (*specify*):

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Individuals performing initial level of care evaluations will be Utah licensed registered nurses employed by the operating agency.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

Utah State administrative rule R414-502 delineates the nursing facility level of care criteria that must be met to qualify for Medicaid reimbursement under the State Plan nursing facility benefit. In accordance with R414-502, in determining whether an applicant has mental or physical conditions that can only be cared for in a nursing facility, or equivalent alternative Medicaid health care delivery programs, must document that at least two of the following factors exist:

a) Due to diagnosed medical conditions, the applicant requires substantial physical maintenance with activities of daily living above the level of verbal prompting, supervision, or setting up;

b) The attending physician has determined that the applicant's level of dysfunction in orientation to person, place or time requires nursing facility care; or equivalent care provided through an alternative Medicaid health delivery program; or

c) The medical condition and intensity of services indicate that the care needs of the applicant cannot be safely met in a less structured setting; or without the services and supports of an alternative Medicaid health care delivery program.

The Operating Agency will provide for an evaluation (and periodic reevaluations) assessment using the standard waiver instrument (MDS-HC) described in Appendix B-6(e), to assess the level of care specified in item 1-F of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

○	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
✓	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.
	The InterRAI MINIMUM DATA SET- HOME CARE (MDS-HC) serves as the standard comprehensive assessment instrument for this waiver and includes all the data fields necessary to measure the individual's level of care as defined in the State Medicaid nursing facility admission criteria. Persons responsible for collecting the needed information and for making the initial level of care determination are trained by staff of the administering agency in the proper application of the MDS-HC instrument and the proper analysis of the MDS-HC data to evaluate level of care eligibility.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The State Operating Agency utilizes the following process to make level of care determinations as follows:

The registered nurse employed by the Operating Agency will conduct a face to face level of care assessment using the standard waiver instrument described in Appendix B-6(e). This assessment is conducted at the individual's current living environment.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○	Every three months
○	Every six months
○	Every twelve months
✓	Other schedule (*specify*):
	A full level of care reevaluation is conducted at a minimum within 12 consecutive months of the last recorded full level of care evaluation, or more frequently, whenever indicated by a significant change in the individual's health status. The individual's level of care is screened at the time a substantial change in the individual's health status occurs, including at the conclusion of an inpatient stay in a medical institution, to determine whether the individual's resultant health status constitutes an ongoing nursing facility level of care.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

✓	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
○	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

The Operating Agency will maintain a tracking system as part of the overall management of eligibility determination and enrollment functions to assure compliance with the provisions of Appendix B-6.

The State Medicaid Agency retains the final authority for oversight of the level of care evaluation process. The oversight function involves an annual review of the level of care evaluations for a sample

of waiver participants representative of the caseload distribution across the program. In the event the sampling identifies potential systemic problems with level of care evaluations, an expanded review would be initiated by the State Medicaid Agency.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Records of level of care evaluations and reevaluations will be maintained in the individual's waiver case record maintained by the Operating Agency.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The administrative case manager is responsible for assisting the applicant in completing the eligibility determination and enrollment process. Once it appears the applicant will likely meet nursing home level of care and generally assesses the individual's LTC needs, the applicant is provided information about the types of services available through the waiver and through the Medicaid nursing home program as part of the pre-enrollment education process.

When the administrative case manager has determined the individual can be adequately served in the community, the individual is informed of any feasible alternatives under the waiver and given the choice of either institutional or home and community based services.

The individual is informed that the SMA provides an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are not given the choice of receiving services in a home or community-based setting or receiving services in a nursing facility.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Freedom of Choice documents are maintained in the individual's case record maintained by the Operating Agency.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Medicaid providers are required to provide foreign language interpreters for Medicaid clients who have limited English proficiency. Waiver clients are entitled to the same access to an interpreter to assist in making appointments for qualified procedures and during those visits. Providers must notify clients that interpretive services are available at no charge. The SMA encourages clients to use professional services rather than relying on a family member or friend though the final choice is theirs. Using an interpretive service provider ensures confidentiality as well as the quality of language translation.

Information regarding access to Medicaid Translation Services is included in the Medicaid information booklet, "Exploring Medicaid," distributed to all Utah Medicaid recipients. Eligible individual may access translation services by calling the Medicaid Helpline.
For the full text of the "Exploring Medicaid" brochure, go to http://hlunix.ex.state.ut.us/medicaid/ and select the "Exploring Medicaid" hyperlink.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	✓	Personal Assistant Services
Adult Day Health	☐	
Habilitation	☐	
Residential Habilitation	☐	
Day Habilitation	☐	
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	☐	
Education	☐	
Respite	☐	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
✓	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Personal Emergency Response System (purchase, testing, installation and service fees)
b.	Local Area Support Coordination Liaision

c.	
d.	
e.	
f.	
g.	
h.	
i.	

Extended State Plan Services *(select one)*

✓	Not applicable
○	The following extended State plan services are provided *(list each extended State plan service by service title)*:
a.	
b.	
c.	

Supports for Participant Direction *(select one)*

✓	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	✓	Consumer Preparation Services
Financial Management Services	✓	

Other Supports for Participant Direction *(list each support by service title)*:

a.	
b.	
c.	

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*
✓	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Administrative Case Management Services are provided by the Utah licensed registered nurses employed by the Operating Agency (DSPD)

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services *(select one)*:

✓	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):
	UCA 62-2-120 and R501-14 of the Utah Human Services Administration requires all persons having direct access to children or vulnerable adults must undergo a criminal history/ background investigation except in the case where the waiver enrollee has chosen to self-employ a family member as part of their self directed program. If the person has lived in Utah continuously for 5 years or more a regional check is conducted. For those not having lived in Utah for 5 continuous years a national check through the FBI is conducted.
○	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

✓	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):
	UCA 62-2-120 and R501-14 of the Utah Human Services Administration requires all persons having direct access to children or vulnerable adults must undergo an abuse screening except in the case where the waiver enrollee has chosen to self-employ a family member as part of their self directed program. The Utah Division of Aging and Adult Services and The Utah Division of Child and Family Services maintain these abuse registries.
○	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

✓	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
○	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type	Facility Type	Facility Type	Facility Type
Admission policies	☐	☐	☐	☐
Physical environment	☐	☐	☐	☐
Sanitation	☐	☐	☐	☐
Safety	☐	☐	☐	☐
Staff : resident ratios	☐	☐	☐	☐
Staff training and qualifications	☐	☐	☐	☐
Staff supervision	☐	☐	☐	☐
Resident rights	☐	☐	☐	☐
Medication administration	☐	☐	☐	☐
Use of restrictive interventions	☐	☐	☐	☐
Incident reporting	☐	☐	☐	☐
Provision of or arrangement for necessary health services	☐	☐	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

✓	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians**. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
○	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
✓	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
	When qualified, any relative other than legally responsible individuals may provide Personal Assistance Services. The same payment controls as described in Appendix C-3:7 and Appendix E-1:1.
○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

The Utah Department of Health will enter into a provider agreement with all willing providers who are selected by recipients and meet licensure, certification and/or other competency requirements.

The Utah Department of Human Services in conjunction with the Bureau of Contract Management will issue a Request for Proposal (RFP) for the purpose of entering into a contract with willing and qualified individuals and public or private non-profit organizations.

The RFP is posted on the Department of Human Services website and remains open, allowing for continuous recruitment. The request includes service requirements and expectations. A review committee evaluates the proposals against the criteria contained in the RFP and selects those who meet the qualifications.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Local Area Support Coordination Liaison

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

✓	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

This service involves: (a) assisting a waiver recipient to identify local area waiver services providers, community based resources, natural supports and to make informed choices when multiple options are available to fulfill the individual's plan of care; (b) establishing a periodic liaison schedule with the recipient as part of the individualized care plan based on assessed need for ongoing localized support; (c) providing the State Administrative RN Case Manager with routine recipient status updates on a periodic basis and immediate notification in the event of substantial changes in the recipient's health, safety, local waiver program environment, or requests for changes in recipient services; and (d) participating in quality assurance evaluations of local waiver services, community based resources, natural supports and the waiver program as a whole, as it pertains to the local area.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limits on the amount, frequency and/or duration are specified on the individual's plan of care and based on assessed need.

Provider Specifications

Provider Category(s) *(check one or both)***:**	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Individual Medicaid provider contracted to provide Local Area Support Coordination Liaison.		Independent Living Centers	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual			Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance

			with 62A-5-103, UCA Medicaid provider contracted to provide Local Area Support Coordination Liaison.
Agency Based			An organization structured as an Independent Living Center consistent with definitions and standards set forth in 29 USC Sec. 796a thru 796f. Medicaid provider contracted to provide Local Area Support Coordination Liaison

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification	Frequency of Verification
Local Area Support Coordination Liaison.	**DSPD**	**Upon initial enrollment and annually thereafter.**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	✓	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Consumer Preparation Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

✓	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

This service is designed to ensure that waiver recipients are prepared to supervise and direct their personal assistance provider services. Consumer Preparation Services includes: (a) instruction in methods of identifying need and effectively communicating those needs to service providers; (b) instruction in management of personal attendant(s) including interviewing, selecting, scheduling, termination, time sheeting, evaluating performance, back up coverage; (c) instruction in addressing problems such as changing levels of personal needs, grievance procedures, emergency coverage, exploitation and abuse. Consumer Preparation Services do not include educational, vocational or prevocational components.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limits on the amount, frequency and/or duration are specified on the individual's plan of care and based on assessed need.

Provider Specifications

Provider Category(s) *(check one or both)***:**	✓	Individual. List types:	✓	Agency. List the types of agencies:
	Individual Medicaid provider contracted to provide Local Area Support Coordination Liaison.		Independent Living Centers	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual			Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA Medicaid provider contracted to provide Local Area Support Coordination Liaison.
Agency-based			An organization structured as an Independent Living Center consistent with definitions and standards set forth in 29 USC

			Sec. 796a thru 796f. Medicaid provider contracted to provide Consumer Preparation Services

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Consumer Preparation Services	**DSPD**	**Upon initial enrollment and annually thereafter.**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	✓	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Personal Response Systems (PERS)

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

✓	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Electronic device that enables an individual to secure help in an emergency through a connection to a signal response center that is staffed by trained professionals on a 24 hour per day, seven days a week basis.

- Personal Emergency Response Systems (PERS) Response Center Service
  Provides ongoing access to a signal response center that is staffed twenty-four hours per day, seven days a week by trained professionals responsible for securing assistance in the event of an emergency.

- Personal Emergency Response System (PERS) Purchase, Rental & Repair
  Provides an electronic device of a type that allows the individual to summon assistance in an emergency. The device may be any one of a number of such devices but must be connected to a signal response center.

- Personal Emergency Response System (PERS) Installation, Testing & Removal
  Provides installation, testing, and removal of the PERS electronic device by trained personnel.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

PERS services are limited to those individuals who live alone, live with others who are not capable of responding in an emergency or who are alone for significant parts of the day and have no regular caretgiver for

extended periods of time, and who would otherwise require extensive routine supervision.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	✓	Agency. List the types of agencies:
				Personal Emergency Response System supplier; and response centers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Emergency Response System Supplier Personal Emergency Response System Installer Personal Emergency Response Center	Current business license, **and** Current business license, **and** Current business license, **and**		Equipment suppliers: FCC registration of equipment placed in the individual's home. Installers: Demonstrated ability to properly install and test specific equipment being handled. Response Centers: 24 hour per day operation, 7 days per week. All providers: Medicaid provider enrolled to provide personal emergency response system services.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
PERS	**DSPD**	**Upon initial enrollment and annually thereafter.**

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Service Specification	
Service Title:	Personal Assistance Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

✓	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Personal Assistance Services are essential to help the waiver recipient achieve maximum independence and may vary depending on the needs of the individual and daily schedule. Services may include: (a) hands-on care of both a medical and non-medical supportive nature, specific to the needs of a medically stable, physically handicapped individual. Skilled medical care and health maintenance may be provided only as permitted by State law and certified by the recipient's physician; (b) housekeeping, chore services and other reasonable and necessary activities which are incidental to the performance of the recipient's care may also be furnished as part of this service when agreed upon by the recipient, personal attendant and the case manager, as outlined in the plan of care.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limits on the amount, frequency and/or duration are specified on the individual's plan of care and based on assessed need.

Provider Specifications

Provider Category(s) *(check one or both)***:**	✓	Individual. List types:	☐	Agency. List the types of agencies:
		Qualified individual selected by the recipient and has a joint DSPD contract/Medicaid Provider Agreement*		

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	✓	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual Personal Attendant		Home Health Aide Certificate of Completion (R432-700-22) OR OTHER STANDARD	be at least 18 years of age; have a Social Security Number and provide verification of such; agree to have a Criminal Background Check; have the ability to read, understand and carry out written and verbal instructions, write simple clinical notes and record messages; be trained in First Aid; be oriented and trained in all aspects of care

			to be provided to the recipient, including medical care and health maintenance; be able to demonstrate competency in all areas of responsibility.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Attendant	**DSPD/Waiver Recipient**	**Prior to the delivery of Medicaid Personal Assistance Services**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	✓	Participant-directed as specified in Appendix E	☐	Provider managed

*All providers receiving state funds appropriated to DSPD are required to enter into a state contract with the DSPD as a provider of services to persons with disabilities. The DSPD state contract is a document separate from the Medicaid Provider Agreement negotiated between each waiver provider and the SMA. A joint DSPD state contract/SMA Provider Agreement is in place for this service.

Service Specification	
Service Title:	Financial Management Services

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
✓	Service is not included in the approved waiver.

Service Definition (Scope)**:**

This service is offered in support of the self-administered services delivery system. Services rendered under this definition include those to facilitate the employment of personal attendants or assistants by the individual or designated representative including: (a) provider qualification verification, (b) employer-related activities including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, fiscal accounting and expenditure reports, (c) Medicaid claims processing and reimbursement distribution, and (d) providing monthly accounting and expense reports to the consumer and the DSPD.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	✓	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Agency-Based	Certified Public Accountant Section 58-26A, UCA, and R156-26A, UCA	Certified by DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA	Medicaid provider enrolled to provide FMS. Under state contract with DSPD as an authorized provider of services and supports to people with disabilities in accordance with 62A-5-103, UCA Financial Management Services

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Financial Services Management Agency	**DSPD**	**Qualifications of FMS providers are assured utilizing the open RFP process as described in Appendix C-2:6; qualifications are verified annually thereafter**

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	✓	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

☐	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*
✓	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*
	Utilizing the score derived from the Personal Assistance Critical Needs Assessment and the needs identified in the MDS-HC, the nurse case manager estimates the individual's prospective budget amount. These assessments function as a benchmark during the annual service planning process. The participant's needs, amount, frequency and duration of available services are discussed with the individual. An individualized waiver services budget is agreed upon. The participant decides how the funds should be allocated among the waiver services. The operating agency provides a central location for all nurse case managers in this waiver; they receive uniform training and engage in a cross review process; thus, assuring the budget process is applied consistently to all waiver recipients across the state. If at any time the individual's service needs change or a health and safety issue arises, the participant contacts their case manager regarding these changes. If the participant requests an increase in their services they may petition in writing for a change. The administrative case manager will complete a new MDS-HC, Critical Needs Assessment and review the present care plan. These documents are presented to The DSPD Associate Director for review. If additional funding is approved, the case manager notifies the participant; changes are made to the individual's service plan and the funding allocation plan to reflect the increase in funding. If the request is denied, the individual receives a Notice of Agency Action and information relating to their hearing rights.
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*

☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
☐	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	

a. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

✓	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☐	Case Manager (qualifications specified in Appendix C-3)
○	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
✓	Other (*specify the individuals and their qualifications):*
	Waiver recipient

b. Service Plan Development Safeguards. *Select one:*

✓	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Prior to the development of the service plan the nurse case manager may refer the individual for Local Area Support Coordinator Liaison services or the individual may call or visit their local ILC This provides the participant and/or family, legal representative with knowledge to identify the local community resources, available local waiver service providers and natural supports in order for the participant to make informed choices when multiple service options are available to fulfill

the individualized care plan. Consumer Preparation services provide training to the participants to ensure they are prepared to recruit, supervise and direct their own personal assistance services to fulfill the individualized care plan.

The plan of care is developed by the recipient in consultation with the administrative case manager and others as necessary and appropriate. The participant has the authority to specify who participates in their care planning process.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Based upon the standard comprehensive assessment process, the type of services and supports the participant needs to prevent institutionalization and assure his/her safety at home and/or a community-based setting are identified. The participant, in consultation with the administrative case manager, a plan of care is developed specifying the array of waiver and non-waiver services to be provided, and for each specified waiver service, the frequency, duration and provider of choice is identified.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The nurse case manager during the comprehensive needs assessment process and service plan development process will identify: Risks posed by the participant's physical and environmental conditions and choice of services and supports to best meet the participant's needs.
In completing the risk analysis, specific emphasis will be placed on identifying risks that would result in a high likelihood harm, death or institutionalization if an interruption in the delivery of a services and supports to the waiver participant occurred.
The risk analysis will be reviewed with the waiver enrollee and others of the person's choosing.
The individual services plan will describe services and supports to be rendered to mitigate risks and will identify back-up plans for the provision of essential services.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During the preparation of the written care plan the participant will be informed in writing by the administrative case manager of waiver service options available to address the identified needs and expectations of the participant. Provider options are made available for each selected waiver service.

The individual will be given a choice of all waiver services and waiver service providers. The

participant selects the service(s) and provider(s) of their choice(s) and it is listed on their plan of care.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The SMA retains final authority for oversight and approval of the service planning process. The oversight function involves at a minimum an annual review of a sample of waiver enrollee's service plans that is representative of the caseload distribution across the program. The specific sample size of each review is selected based on the identified focus of the review and the number of reviews determined to be necessary to evaluate the waiver's performance. If the sample evaluation identifies system-wide service planning problems, an expanded review is initiated by the SMA.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
○	Every twelve months or more frequently when necessary
✓	Other schedule (*specify*):
	The plan of care will be reviewed as frequently as necessary, with a formal review at least every 12 months, completed during the calendar month in which it is due. Should the recipient experience a significant change in his/her health status, the administrative case manager or the recipient will initiate a review of the plan of care to assure appropriate services are defined to meet the recipient's care needs. The plan of care revisions will be completed in a time frame consistent with the nature of the change in status, but in no case will the time frame exceed 14 days from the date the administrative case manager was notified of the change in status. If the recipient was in an acute care facility, the plan of care will be reviewed within 7 days from the date the administrative case manager was notified that the recipient returned to his/her place of residence.

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
✓	Operating agency
☐	Case manager
☐	Other (*specify):*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

This waiver maintains a consumer driven focus, as such the consumer has a responsibility to identify areas of concern, and report problems to his/her administrative case manager. A minimum of annually, the administrative case manager and consumer have a face-to-face visit. Additional contacts take place by phone on an as-needed basis.

The operating agency (DSPD) is responsible for designing and implementing a quality management program. This program includes procedures for overseeing the performance of the needs assessment process, service plan development and implementation process.

Each month the administrative case manager reviews the billing statement from the FMS provider and a monthly budget sheet from the operating agency's financial analyst. If these documents reveal over/under utilization the case manager contacts the participant to discuss the reasons why and revise the budget if necessary.

Additionally, a three year trend report is generated for each participant. The administrative case manager and the participant go over this report annually to identify trends in utilization/expenditures in order to have the most accurate budget possible.

Activities conducted by the nurse case manager such as the review of monthly FMS statements, review of monthly provider summary notes, risk assessment and contingency plan development, annual satisfaction surveys and prompt response to waiver recipient's inquiries form the "front line" of service plan and health and welfare monitoring.

DSPD is responsible to organize the content and timeframes of its quality assurance program. Program performance reviews are to be done by DSPD staff who are not responsible for service planning and delivery to assess the accuracy and effectiveness of the link between the determination of need, the service plan, the implementation of case management services and the ongoing evaluation of progress towards the individual's stated goals.

At a minimum, an annual review will be conducted by DSPD utilizing an adequate sample to evaluate program performance.

All plans of care are subject to annual and periodic post-payment review and approval by the SMA. A sample of care plans will be reviewed each waiver year. Significant findings from those reviews will be reported to the operating agency. The operating agency will be required to develop a plan of correction with specific timeframes for completion. The SMA will conduct follow-up reviews to ensure the plan of correction is implemented and sustained.

b. Monitoring Safeguards. *Select one:*

✓	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

✓	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
○	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
✓	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

Self-Administered Services means service delivery that is provided through a non-agency based provider. Under this method, individuals hire individual employees to perform personal assistance waiver services. The individual is then responsible to assure employee qualifications, hire, supervise, train, schedule, assure time sheet accuracy, etc. of the employee(s).

The self administered services method requires the use of a Financial Management Service to assist with managing employer-related financial responsibilities associated with self administered services.

If the needs assessment process has indicated the waiver participant would benefit from access to Consumer Preparation and Local Area Support Liaison services, the nurse case manager will refer them to a provider qualified to provide the knowledge base for the individual to successfully direct their personal attendant services in their local area.

The participant has budget authority as it pertains to their personal assistance staff. The recipient decides how many employees they can afford to hire within the overall budgeted amount, the wages to be paid and the amount of hours worked. They are responsible to review all employee timesheets for accuracy and submit them to the FMS agent for payment. The FMS agent sends the employer information after each pay period detailing what was paid and the amount remaining in their budget.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
✓	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

✓	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
☐	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

✓	Waiver is designed to support only individuals who want to direct their services.
○	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

During the eligibility and enrollment process, the operating agency provides the individual with an orientation, including written materials, describing the self-administered services method. At that time it is explained to the individual that the personal assistance services component of the waiver utilizes the self-administered services model, the mandatory use of a qualified FMS agent, and the responsibilities and potential liabilities of becoming an employer. This information enables the individual to make an informed choice.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

✓		The State does not provide for the direction of waiver services by a representative.
○		The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:
	☐	Waiver services may be directed by a legal representative of the participant.
	☐	Waiver services may be directed by a non-legal representative freely chosen by an adult

	participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-Directed Waiver Service	Employer Authority	Budget Authority
PERS	☐	☐
Local Area Support Coordination Liaison	☐	☐
Consumer Preparation	☐	☐
Personal Assistance Services	✓	✓
Financial Management Services	☐	☐
	☐	☐

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

✓	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*	
	☐	Governmental entities
	✓	Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i.*	

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

✓	FMS are covered as the waiver service entitled as specified in Appendix C-3.		Financial Management Services
○	FMS are provided as an administrative activity. *Provide the following information:*		
	i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:	
	ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:	
	iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each*	

		that applies):
		Supports furnished when the participant is the employer of direct support workers:
	☐	Assist participant in verifying support worker citizenship status
	☐	Collect and process timesheets of support workers
	☐	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
	☐	Other *(specify):*
		Supports furnished when the participant exercises budget authority:
	☐	Maintain a separate account for each participant's participant-directed budget
	☐	Track and report participant funds, disbursements and the balance of participant funds
	☐	Process and pay invoices for goods and services approved in the service plan
	☐	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other services and supports *(specify)*:
		Additional functions/activities:
	☐	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
	☐	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
	☐	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
	☐	Other *(specify):*
iv.		**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
✓	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: **Consumer Preparation Services**
✓	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*
	The State/Regional Administrative Waiver Case Manager, as an employee of the Division of Services for People with Disabilities, is responsible to oversee and / or perform the following essential activities directly connected to ensuring the proper and efficient operation of the Medicaid home and community-based waiver for individuals with severe physical disabilities: · Compile, coordinate and forward (to Medicaid's Eligibility Services and Long Term Care Bureau respectively) necessary documentation to support timely medical and Medicaid eligibility determination for waiver applicants and recipients; · Oversee and actively participate in the plan of care process and periodically monitor the delivery of services; · Assist recipients to obtain and maintain needed Medicaid (state plan and waiver) benefits; · Regularly evaluate the effectiveness of the waiver; · Monitor, evaluate, train, and when appropriate, delegate medical assistance services to personal attendants (only as authorized by the recipient's physician and in accordance with state laws); B. Provide consultation to Local Area Support Coordination Liaisons about waiver recipient issues and waiver service delivery. C. Supervise waiver-related activities of Local Area Support Coordination Liaisons. · Coordinate with the state Medicaid agency to recommend modifications to policies, procedures and standards; · Design / provide /arrange as appropriate, the delivery of provider training and instruction; · Conduct provider recruitment and oversight / Quality Assurance activities. Identify and assist qualified individuals and agencies to enroll as providers of waiver services; · Conduct outreach activities to identify and inform potential recipients, their families and interested others in the community about the waiver program; · Ensure applicant / recipient rights, including rights to fair hearing; · Oversee development and implementation of fee schedule criteria and protocols;

	· Maintain and manage waiting list; · Coordinate waiver services with enrolled Medicaid Nursing Facilities; develop and implement procedures and protocols to facilitate clients' transition between nursing facilities and community-based settings; · Develop and implement internal quality assurance protocols; participate in joint program reviews with the state Medicaid agency; · Compile information, data and reports to support the above functions and as required by the state Medicaid agency and CMS; · Other duties as jointly agreed to by the state Medicaid agency and the Division of Services for People with Disabilities and covered in the interagency agreement. QUALIFICATIONS · Licensed in the State of Utah as a Registered Nurse in accordance with Title 58, Occupational and Professional Licensing, Utah Code Annotated, 1953 as amended; and · One year of paid professional experience in working with individuals with severe physical disabilities. Preference given to applicants with one year of direct nursing services with individuals with severe physical disabilities

k. Independent Advocacy *(select one)*.

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
✓	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

The Physical Disabilities Waiver supports only those individuals that are capable of self-directing their own services. The Division of Health Care Financing (DHCF) in partnership with the Division of Services for People with Disabilities (DSPD) will compile information on voluntary disenrollments, and routine involuntary disenrollments.

1. Voluntary disenrollments are cases in which participants choose to initiate disenrollment from the waiver. These cases require written notification to the Division of Health Care Financing by the Division of Services for People with Disabilities within 30 days from date of disenrollment. The Division of Services for People with Disabilities will maintain documentation detailing the discharge planning activities completed with the waiver enrollee as part of the disenrollment process.

2. Pre-Approved involuntary disenrollments are cases in which participants are

involuntarily disenrolled from a home and community based waiver program for any one or more of the specific reasons listed below:

a. Participant death;

b. Participant no longer meets financial requirement for Medicaid program eligibility;

c. Participant has moved out of the State of Utah; or

d. Participant whereabouts are unknown.

Pre-Approved involuntary disenrollments require written notification to the Division of Health Care Financing by the Division of Services for People with Disabilities within 30 days from date of disenrollment. No Division of Health Care Financing prior review or approval of the decision to disenroll is required. The Division of Services for People with Disabilities will maintain documentation detailing the discharge planning activities completed with the waiver enrollee as part of the disenrollment process.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The Physical Disabilities Waiver supports only those individuals who are capable of directing their own services. Special circumstance disenrollments are cases that are non-routine in nature and involve circumstances that are specific to the individual involved. Examples of this type of disenrollment include the waiver participants no longer meets the corresponding institutional level of care requirements, the participants health and safety needs cannot be met by the current program's services and supports, or the participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate an individual support plan that meets minimal safety standards.

Special circumstance disenrollments require review and authorization prior to disenrollment to facilitate:

a. Appropriate movement amongst programs;

b. Effective utilization of program potential;

c. Effective discharge and transition planning;

d. Provision of information, affording participants the opportunity to exercise all rights; and

e. Program quality assurance/quality improvement measures.

The special circumstance disenrollment review process will consist of the following activities:

a. The operating agency recommending disenrollment will compile information to articulate the disenrollment rationale.

b. The operating agency will then submit the information to the state-level program management staff for their review of the documentation of support coordination activities and of the disenrollment recommendation.

c. If state-level program management staff concurs with the operating agency's recommendation, the case will be forwarded to the DHCF for a final decision.

d. The DHCF will review and assure the available array of Medicaid waiver and non-waiver services, and other available resources have been fully utilized to meet the individual's health and safety needs.

e. The DHCF will facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.

f. The DHCF final disenrollment decision will be communicated to both the operating agency and the state-level program management staff in writing.

If the disenrollment is approved, the operating agency will provide to the individual the required written notification of agency action and right to fair hearing information.

The operating agency will initiate discharge-planning activities sufficient to assure a smooth transition to an alternate Medicaid program or to other services.

E. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1	150	150
Year 2	150	150
Year 3	150	150
Year 4 (renewal only)	150	150
Year 5 (renewal only)	150	150

Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*
✓	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Check the decision making authorities that participants exercise*:

✓	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
✓	Hire staff (common law employer)
✓	Verify staff qualifications
✓	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	The operating agency (DSPD) is responsible to pay any fees associated with background investigations.
✓	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
✓	Determine staff duties consistent with the service specifications in Appendix C-3.
✓	Determine staff wages and benefits subject to applicable State limits
✓	Schedule staff
✓	Orient and instruct-staff in duties
✓	Supervise staff
✓	Evaluate staff performance
✓	Verify time worked by staff and approve time sheets
✓	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply***:**

☐	Reallocate funds among services included in the budget
✓	Determine the amount paid for services within the State's established limits
✓	Substitute service providers
✓	Schedule the provision of services
✓	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
✓	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
✓	Identify service providers and refer for provider enrollment
☐	Authorize payment for waiver goods and services
✓	Review and approve provider invoices for services rendered
☐	Other *(specify):*

ii. Participant-Directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Utilizing the score derived from the Personal Assistance Critical Needs Assessment and the assessment information from the MDS-HC, the administrative case manager estimates the individual's prospective budget amount. During the annual service planning process, the participant's needs and available services are discussed with the individual. An individualized waiver services budget is agreed upon. The participant, in collaboration with the Administrative Case Manager, decides how the funds should be allocated among the waiver services to assure the health and safety of the participant.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

If at any time the individual's service needs change or a health and safety issue arises, the participant is responsible to contact their administrative case manager with these changes. If the participant requests an increase in their services they may petition in writing for a additional funds. The administrative case manager will complete a new MDS-HC, Critical Needs Assessment and review the present care plan. These documents are presented to the DSPD Associate Director for review.

If additional funding is approved, the case manager notifies the participant, changes are made to the individual's service plan and the funding allocation plan. If the request is denied, the individual receives a Notice of Agency Action and information relating to their hearing rights.

iv. Participant Exercise of Budget Flexibility. *Select one:*

○	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
✓	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Each month the administrative case manager reviews the billing statement from the FMS provider and a monthly budget sheet from the operating agency's financial analyst. If these documents reveal over/under utilization the case manager contacts the participant to discuss the reasons why and revise the budget if necessary. Additionally, a three year trend report is generated for each participant. The administrative case manager and the participant go over this report annually to identify trends in utilization/expenditures in order to have the most accurate budget possible.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

1. DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

An individual and the individual's legal representative will receive a written Notice of Agency Action from the administrative case manager if the individual is not given the choice of home and community-based services or institutional care, or who is denied the waiver service(s) of their choice, or the provider(s) of their choice, or who is found ineligible for the waiver program.

The Notice of Agency Action delineates the individual's right to appeal the decision. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions, but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing (Form 490S) and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

The waiver care plan serves as the formal document identifying services that the waiver enrollee receives based on the comprehensive needs assessment. At the time a substantial change in a waiver enrollee's condition results in a change in the person's assessed needs, the individual support plan is revised to reflect the types and levels of service necessary to address the current needs. If the revisions to the individual support plan result in termination of a covered waiver service, reduction in the waiver services being received, or a suspension or denial of services that the individual feels are necessary to prevent institutionalization, the individual or legal representative has the right to appeal the decision to revise the individual support plan. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions, but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing (Form 490S) and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.

2. SINGLE STATE AGENCY

The State Medicaid Agency provides individuals applying for or receiving waiver services an opportunity for a hearing upon written request (see A.1. above), if they are:

a. Not given the choice of institutional (NF) care or community-based (waiver) services;

b. Denied the waiver provider(s) of their choice if more than one provider is available to render the service(s);

c. Denied access to waiver services identified as necessary to prevent institutionalization; or

d. Experience a reduction, suspension, or termination in waiver services identified as necessary to prevent institutionalization.

It is the policy and preference of the single State agency to resolve disputes at the lowest level through open discussion and negotiation between the involved parties.

DIVISION OF HEALTH CARE FINANCING
ADMINISTRATIVE HEARING PROCEDURES

All hearings before the Division of Health Care Financing except as otherwise set forth shall be conducted as a formal hearing.

Advance Notice

1. Each individual who is affected by an adverse action taken by DHCF or its administrative Fiscal Agent will be given advance notice of such action:

2. A notice must contain:

    a. A statement of the action DHCF or its administrative Fiscal Agent intends to take;
    b. The date the intended action takes effect;
    c. The reasons for the intended action;
    d. The aggrieved person's right to request a formal hearing before DHCF, when applicable, and the method by which such hearing may be obtained from DHCF;
    e. A statement that the aggrieved person may represent himself or use legal counsel, relative, friend, or other spokesman at the formal hearing; and,
    f. An explanation of the circumstances under which Medicaid coverage or reimbursement will be continued if a formal hearing is timely requested.
    g. DHCF will mail an advance notice at least ten calendar days before the date of the intended action.

Request for Formal Hearing

1. An aggrieved Medicaid applicant/recipient/provider may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later, by DHCF of an action or inaction.

2. Failure to submit a timely request for a formal hearing will constitute a waiver of a person's formal hearing or pre-hearing rights. A request for a hearing shall be in writing, shall be dated, and shall explain the reasons for which the hearing is requested.

3. The address for submitting a "Request for Hearing/Agency Action" is as follows:

Utah Department of Health
Division of Health Care Financing
Director's Office/ Formal Hearings
P.O. Box 31431
Salt Lake City, UT 84131-9988

Reinstatement/Continuation of Services

1. DHCF may reinstate services for recipients or suspend any adverse action for recipients/providers if an aggrieved person requests a formal hearing not more than ten (10) calendar days after the date of action.

2. DHCF must reinstate or continue services for recipients or suspend adverse actions for providers until a decision is rendered after a formal hearing if:

    a. Adverse action is taken without giving the ten-day advanced mailed notice to a recipient/provider in all circumstances where such advance notice is required;

    b. In those circumstances where advance notice is not required, the aggrieved person requests a formal hearing within ten calendar days following the date the adverse action notice is mailed; or

    c. DHCF determines that the action resulted from other than the application of federal or state law or policy.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

✓	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
○	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Department of Human Services has an informal hearings process and the Division of People with Disabilities has an informal dispute resolution process. The informal dispute resolution process is designed to respond to a participant's concerns without unnecessary formality. The dispute resolution process is not intended to limit a participant's access to formal hearing procedures; the participant may file a Request for Hearing any time in the first 30 days after receiving Notice of Agency Action.

When DSPD receives a Hearing Request Form (490S) a three step resolution process begins with:

1. The Division staff explain the regulations on which the action is based and attempt to resolve the disagreement.
2. If resolution is not yet reached, Division staff arranges a Region Review meeting between the individual and/or their legal representative and the Region Supervisor and/or the Region Director.
3. If the Region Review process is unsuccessful, Division staff arrange a Division Review meeting between the individual and/or their legal guardian and the Division Director and Region Director.

If the three step resolution process is not able to resolve the problem, the individual may request an informal hearing with a hearing officer with the Department of Human Services Office of Administrative Hearings.

This informal hearing reviews the information DSPD used to make a decision or take an action as well as review information from the participant and/or their legal representative demonstrating why the decision or action is not correct.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

✓	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

Utah Department of Human Services, Division of People with Disabilities and Utah Department of Health, Division of Health Care Financing, Long Term Care Bureau

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DSPD Policy 1.11 Conflict Resolution requires the case manager to provide information to recipients on the conflict resolution process and on how to contact the case manager's supervisor. The supervisor reviews all complaints submitted either orally or written and any relevant information submitted with the complaint. The supervisor will take appropriate action to resolve the dispute and respond to all parties concerned. If the parties are unable to resolve the dispute either party may appeal to the Region Director. The Region Director will meet with the parties and review any evidence presented. The Region Director shall determine the best solution for the dispute. The Region Director will prepare a concise written summary of the finding and decision and send it to the parties involved. Either party may request an independent review of they do not agree with the Region Director's decision. Based on interviews with the parties and a review of the evidence, the independent reviewer will prepare for the Division Director a written summary of the factual findings and recommendations. Based on the independent reviewers report the Division Director will determine the appropriate resolution for the dispute and shall implement any necessary corrective action.

Waiver recipients may also file a written or verbal complaint/grievance with the Dept. of Human Services Ombudsman. This Ombudsman is specifically assigned to the Operating Agency, although operates independent of them. When the Ombudsman receives a complaint there is an investigation involving all pertinent parties. The Ombudsman then works with the parties to come to a resolution.

Both the Dept. of Human Services and the Dept. of Health have constituent services available. Participants may call and verbally register a complaint/grievance. The constituent services representative ensures the caller is referred to the appropriate party for problem resolution. The constituent services representative follows up with both parties within 5 days to ensure resolution.

Long Term Care Bureau (LTCB) staff members receive complaints/grievances. Recipients may file a written or verbal complaint; it is logged into a data base. An investigation is conducted with all pertinent parties involved. The staff member(s) reviews the waiver implementation plan and applicable rule/policy/procedure. A decision is communicated in writing to the appropriate parties and if

indicated, information about the right to a hearing is included.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

R539-5-6 requires the individual/ their representative or a provider agency to report to the administrative case manager if at any time the participant's health and/or safety is jeopardized. Such instances may include, but are not limited to:
1. Actual or suspected incidents of abuse, neglect, exploitation or maltreatment per the DHS/DSPD Code of Conduct and Utah Code Annotated Sections 62-A-3-301 through 321 (mandatory reporting to Adult Protective Services)
2. Drug or alcohol misuse
3. Medication overdose or error requiring medical intervention
4. Missing person
5. Evidence of a seizure in person with no seizure diagnosis
6. Significant property destruction ($500.00 or more)
7. Physical injury requiring medical intervention
8. Law enforcement involvement
9. Emergency hospitalizations

Deaths of a waiver recipient are subject to a full review of the circumstances surrounding the death to include a review of the most recent year of services documentation by the DSPD Fatality review Coordinator.

Incidents that require reporting may be done verbally and must be made within 24 hours. Within 5 days the person reporting the incident completes the DSPD Form 1-8. If the person reporting is unable to complete the DSPD Form 1-8, accommodations are made and the administrative case manager writes the report.

The administrative case manager reviews the information, develops and implements a follow-up plan, as appropriate. The form and any follow-up conducted are filed in the individual's case record.

Incident reports are compiled, logged into the DSPD electronic database, analyzed and trends are identified. The information is utilized by the DSPD to identify potential areas for quality improvement. The DSPD generates a summary report of the incident reports annually (at minimum) and submits to the SMA.

If the SMA detects systemic problems DSPD must address DSPD will submit a plan of correction to the SMA. All plans of correction are subject to acceptance by the SMA. The SMA will conduct follow-up activities to determine that systems corrections have been achieved and are sustaining.

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Consumer Preparation Services provides the participant with information/training on the following topics: (a) how to avoid theft/security issues; (b) maintaining personal safety when recruiting/interviewing potential employees; (c) assertiveness/boundaries/rules with employees; (d) maintaining personal safety when firing an employee; (e) when and how to contact and report instances of abuse, neglect, exploitation; (f) resources on a local level to assist the participant if they are a victim of abuse, neglect or exploitation

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

The operating agency has responsibility for receiving, reviewing and responding to critical incidents.

Incidents involving suspected or actual abuse, neglect or exploitation will be reported to APS in accordance with Utah State Law 76-5-111 and State Rule R510-302. The operating agency will also report these instances to the SMA within 48 hours.

The operating agency will assure immediate interventions are taken to protect the health and welfare of the recipient (as circumstances warrant). An investigation is conducted to determine the facts, if the needs of the recipient have changed and warrant an updated needs assessment and identify preventive strategies for the future. The service plan is amended as dictated by the circumstances. The timeframe for completion of the investigation is 5 days from the date of notification.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The operating agency has responsibility for oversight of critical incidents and events.

Incident reports are compiled, logged into the DSPD electronic database, analyzed and trends are identified. The information is utilized to identify prevention strategies on a system wide basis and identify potential areas for quality improvement.

The DSPD generates a summary report of the incident reports annually (at minimum) and submits it to the SMA.

If the SMA detects systemic problems either through this reporting mechanism or during the SMA's program review process, DSPD will be requested to submit a plan of correction to the SMA. The plan of correction will include the interventions to be taken and the time frame for completion.

All plans of correction are subject to acceptance by the SMA. The SMA will conduct follow-up activities to determine that systems corrections have been achieved and are sustaining.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed.

a. Applicability. *Select one:*

✓	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(do not complete the remaining items)*	
○	This Appendix applies. Check each that applies:	
	☐	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	☐	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete items G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

c. Safeguards Concerning the Use of Restrictive Interventions

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

○	**Yes**. This Appendix applies *(complete the remaining items)*.
✓	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

○	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

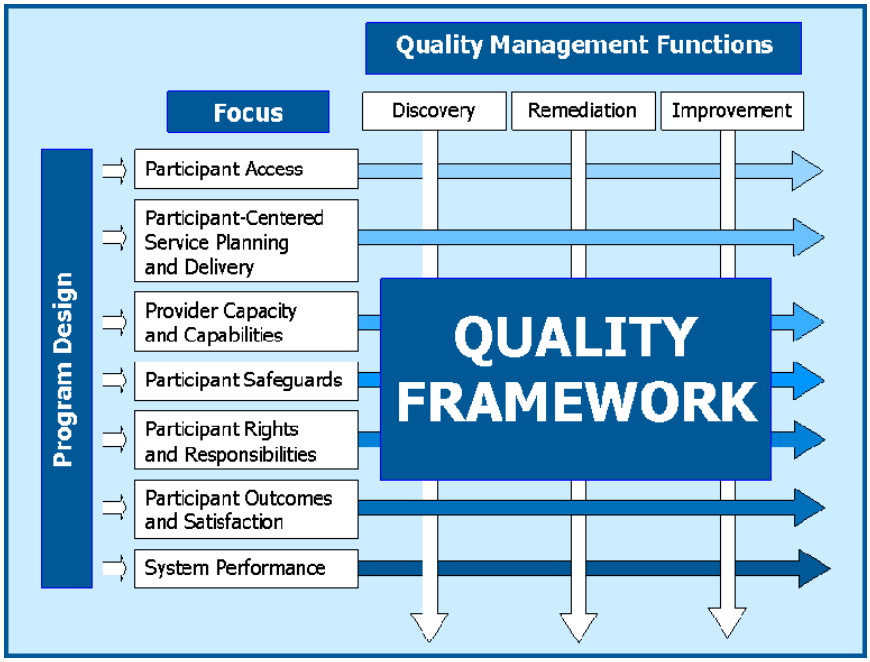
ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	(b) Specify the types of medication errors that providers are required to *record:*
	(c) Specify the types of medication errors that providers must *report* to the State:
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix H: Quality Management Strategy



Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy**.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the waiver is:

Introduction:
The purpose of the Quality Management Strategy is to evaluate, improve and enhance the quality of services provided to consumers of the HCBS Medicaid Waiver for Persons with Physical Disabilities. It includes processes to assess the Waiver for program compliance with federal and state standards and assurances and methods for remediation and improvement. The Strategy is a multi level approach to quality assurance and quality improvement of the Physical Disabilities (PD) Waiver. The Long Term Care Bureau (LTCB) has administrative authority over the PD Waiver. The Division of People with Disabilities is the waiver operating agency. DSPD conducts quality assurance activities to assure compliance with the assurances in the PD Waiver State Implementation Plan.

Part I. Assurances, describes the quality assurance activities that are conducted for each of the federal assurances. *Part II. Reports*, identifies the types of reports that will be generated and the distribution of these reports. *Part III. Evaluation and Revision* of the Quality Management Strategy describes the plan for periodically reviewing and revising the quality management strategy.

Part I. Assurances

This section addresses the quality assurance activities that are conducted for each of the Assurances in the State Implementation Plan by the waiver operating agency. It also describes activities of the LTCB with respect to evaluating the effectiveness of these quality assurance and quality improvement activities. Included in this section are the **processes** that address compliance of each assurance, the current activities that are utilized for **discovery (including monitoring, data collection and analysis)** and **remediation/improvement** strategies.

Level of Care
Process: The waiver operating agency RN case managers employed by DSPD completes an assessment and Level of Care (LOC) determination for each PD Waiver participant.
Discovery: The DSPD Quality Management Unit conducts an annual Internal Quality Assurance Review. They review a representative sample of case records to determine the accuracy of LOC determinations. A report of the results of the internal review will be completed and submitted to the Division's Associate Director who then reviews it with the administrative case managers. These reports are shared with the SMA and utilized to identify trends or compliance issues with LOC assurances.
Remediation/Improvement: If the findings of the DSPD Quality Management Unit report indicate a negative finding a corrective action plan is developed and implemented. If ongoing or annual reviews conducted by the BLTC reveal a trend in inaccurate level of care determinations, the LTCB will require the DSPD to provide plans of correction within specific time frames to correct the problems. The LTCB will conduct follow up activities to assure that corrections are sustaining.

Individual Plans of Care
Process: Assessments and re-assessments are conducted by the waiver operating agency.

Participants are provided a "Provider Choice Form" by the waiver operating agency to assist them in obtaining information about and selecting from qualified providers. The case managers and Local Area Support Liaisons assist participants to find out more information about individual providers. There is an annual review of the individual plan of care; case managers monitor participants by phone and through contact with the Independent Living Centers to assess the effectiveness and adequacy of services. The Local Area Support Liaison at the ILC submits an activity log and a monthly summary with the billing each month to the case manager. These documents keep the administrative case manager informed about the individual's progress towards reaching their objectives in the plan of care. Case managers make revisions to care plans as needed based on ongoing and annual assessments.

Discovery: The DSPD Quality Management Unit conducts an annual Internal Quality Assurance Review. They review a representative sample of case records to determine if plans of care match the assessed needs, are adequate in scope, duration and frequency of services provided and are being implemented. Annually, the case managers conduct a satisfaction survey to determine if the participant is satisfied with the program. In addition, the LTCB reviews plans of care during its annual review of the PD Waiver.

Remediation/Improvement: If the findings of the DSPD Quality Management Unit report indicate a negative finding a corrective action plan is developed and implemented. If the results of the annual participant survey reveals areas where the program could improve a strategy is developed to address the participants' concerns and corrective action is implemented. If ongoing or annual reviews conducted by the LTCB reveal a trend in unacceptable plans of care, the LTCB will require the DSPD to provide plans to correction within specific time frames to correct the problems. The LTCB will conduct follow up activities to assure that corrections are sustaining.

Qualified Providers

Process: All providers must have a Medicaid provider agreement with the Department of Health except in the case of personal attendants employed directly by waiver clients. In that case, the Financial Management Services agent must have a completed copy of the employer agreement in the employment record of each personal attendant. In addition, providers of health care to vulnerable adults are subject to criminal background checks and abuse registry screening. In the event a qualified personal attendant provider requested direct billing access to the Medicaid Agency, the State would accommodate this request.

Discovery: Annually, the case managers conduct a satisfaction survey to determine if the participant is satisfied with the program. If the results of the annual participant survey reveal areas where the program could improve a strategy is developed to address the participants' concerns and corrective action is implemented. Contract Analysts from the DSPD conduct an annual review in which provider licenses and certifications are reviewed. The results of this review are given to the SMA. In addition, the LTCB reviews a random sample of provider licenses and certifications on a periodic basis. The LTCB conducts annual reviews of the PD Waiver including interviews with participants regarding provider performance. The LTCB reviews the Freedom of Choice documents to assure the participant had a choice between HCBS or institutional services and that they were given information about qualified providers from which to choose services. The LTCB contacts DSPD with issues or concerns related to choice, providers or the participants that are receiving services from them.

Remediation/Improvement: If ongoing or annual reviews conducted by the LTCB reveal unacceptable performance by providers, the LTCB will require the DSPD to provide plans of correction within specific time frames to correct the problems. The LTCB will conduct follow up

activities to assure that corrections are sustaining.

Health and Welfare

Process: Case managers and/or Local Area Support Liaisons will report suspected incidents of abuse, neglect and exploitation of an adult to the Adult Protective Services (APS) unit of the Division of Aging and Adult Services (DAAS). Case managers and/or Local Area Support Liaisons work closely with local APS workers to resolve these issues. When concerns regarding health and welfare do not rise to the level that APS can intervene, the case managers and the Local Independent Living Center's Support Liaison put additional safeguards in place, whenever possible. At each contact between the case manager and the participant, the case manager strongly encourages the use of smoke and carbon monoxide detectors, fire extinguishers and an emergency kit.

Discovery: Through ongoing and annual assessments, communication with participants and the Independent Living Centers, DSPD will monitor the health and safety of the individual. During annual reviews the LTCB will conduct interviews with participants, their families and providers to assure that participants' health and welfare needs have been identified and addressed.

Remediation/Improvement: If annual reviews conducted by the BLTC reveal a trend in health and welfare issues, the BLTC will require the DSPD to provide plans of correction within specific time frames to correct the problems. If abuse, neglect and/or exploitation of an individual is identified during the annual review, the BLTC will contact DSPD for immediate correction and, when appropriate, make a referral to APS. The BLTC will conduct follow up activities to assure that corrections are sustaining.

Administrative Authority

Discovery: The DSPD Quality Management Unit conducts an annual Internal Quality Assurance Review. A thorough review of the component parts of the PD Waiver is conducted along with a review of the financial processes and provider claims. Results of the findings and plans of correction, if any, are sent to the LTCB. The LTCB reviews each report and requests additional information or follow up when necessary.

Remediation/Improvement: The LTCB conducts an annual review of the PD Waiver Program. The type of review will be determined based an analysis of several sources: issues identified in the DSPD Quality Management Unit annual report, issues identified in the previous year's LTCB Annual Review, focus areas selected by the LTCB, issues identified in the annual participant survey. A plan will be developed each year that identifies the sample criteria. An annual review will not be conducted during a year that the Waiver Program is reviewed by CMS.

Financial Accountability

Process: The administrative case manager reviews each participants monthly billing statements from the financial management agent and a monthly budget sheet generated by the DSPD Financial Analyst.

Discovery: Annually the DSPD Fiscal Review and Audit Unit reviews a sample of payment histories and the documentation to support those payments to assure that the providers have billed only for services that have been authorized and that the rate billed is correct. The sample includes information from all of the contract providers and individuals who are self-directing their own programs. Post-payment reviews are conducted by the Medicaid agency. This includes reviews a

sample of individual written support plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the support plan, (2) that the individual is receiving the services identified in the support plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the support plan.
Remediation: When DSPD or the LTCB determine billing errors, providers are required to make corrections.

Part II. Reports

DSPD prepares reports of their monitoring audits and when necessary generate a corrective action plan. All corrective actions have time frames for a response. Follow-up is done on all corrective action. Copies of all reports are sent to the LTCB. The LTCB distributes the findings of its annual report to the Medicaid Director and DSPD.
Quality Improvement Initiative: The LTCB will develop a protocol regarding the distribution of reports to additional appropriate entities.

Part III. Evaluation and Revision of the Strategy

The Physical Disabilities Waiver Quality Management Strategy is a dynamic document. It is designed to reflect innovations, modifications and current trends with respect to home and community based services long term care programs. Hence, the areas of emphasis for each fiscal year review of the Physical Disabilities Waiver may change at any time based on additional information from any source that may play a part in the waiver's development and implementation. At least annually the Quality Management Plan will be reviewed for its effectiveness to meet the assurances, sustain corrections, and determine quality improvement initiatives.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as CMS may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted. The State conducts a single audit in conformance with the Single Audit Act of 1984, Public Law 98-502.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES ROLE AND PROVIDER CONTRACTING REQUIREMENT

The Division of Services for People with Disabilities (DSPD) is the designated State Agency responsible for planning and developing an array of services and supports for persons with disabilities living in Utah. State statute 62A-5-103, 1953 as amended, sets forth DSPD's authority and responsibility to:

1. Plan, develop and manage an array of services and supports for individuals with disabilities;
2. Contract for services and supports for persons with disabilities;
3. Approve and monitor and conduct certification reviews of approved providers;
4. Act as a Fiscal Agent to receive and disburse funds; and
5. Develop standards and rules for the administration and operation of programs operated by or under contract with the division.

In accordance with DSPD's lead role and designated responsibilities, monies allocated for services for persons with disabilities are appropriated by the State Legislature to DSPD which in turn contracts with public and private providers for the delivery of services and supports necessary to implement all programs funded partially or in-full with State monies. To assure the proper accounting for State funds, DSPD enters into a written State contract with each provider which includes a stipulation that claims for services provided be submitted to and paid by DSPD. This State-specific requirement applies regardless of whether: 1) the State funds are used for State-funds only programs or are used to draw

down FFP as part of a 1915(c) HCBS Waiver program, or 2) the target population includes Medicaid-eligible citizens. The State contract is the sole responsibility of, and is managed by, DSPD's parent agency, the Department of Human Services.

In the case where a portion of the annual Legislative appropriation is designated for use as State matching funds for the Medicaid 1915(c) HCBS Waiver described herein, DSPD certifies to the State Medicaid Agency, through an interagency agreement, that the State funds will be transferred to the State Medicaid Agency in the amount necessary to reimburse the State match portion of actual Medicaid expenditures paid through the MMIS system for waiver services.

As a result of the State's organizational structure described above:

1. All providers participating in this 1915(c) HCBS Waiver must: a) fulfill the DSPD State contracting requirement as one of the waiver provider qualifications related to compliance with State law, and b) abide by the provision of the State contract to bill through DSPD for services provided.
2. The State Medicaid Agency reimburses DSPD for any interim payments that are made for legitimate waiver service claims during the time the clean claim is being processed through the MMIS system.
3. The State Medicaid Agency recovers from DSPD the State matching funds associated with the waiver expenditures.
4. The State Medicaid Agency approves all proposed rules, policies, and other documents related to the 1915(c) waiver prior to adoption by the DSPD policy board.

STATE MEDICAID AGENCY ROLE AND PROVIDER CONTRACT REQUIREMENT

The State Medicaid Agency, in fulfillment of its mandated authority and responsibilities related to the 1915(c) HCBS Waiver program, retains responsibility for negotiating a Medicaid Provider Agreement with each provider of waiver services. Unlike the DSPD State contract required of all providers of services to persons with disabilities who receive State monies, the Medicaid Provider Agreement is specific to providers of Medicaid funded services.

JOINT DSPD STATE CONTRACT/SMA PROVIDER AGREEMENT

The Personal Assistance provider category presents particular challenges to the effective and efficient operation of this Medicaid waiver. It is anticipated that this will be the sole instance in which individuals serving as Personal Assistants will be associated with the Medicaid program as enrolled providers. It is also anticipated that the number of participating Personal Attendants will be significant, thus imposing a substantial administrative effort to negotiate required contracts and agreements. Therefore, for purposes of the effective management of the Personal Assistance (attendant) waiver service category only, a joint DSPD State Contract/SMA Provider

Agreement has been developed. The joint state contract/provider agreement complies with the content requirements of Medicaid Provider Agreements and requires the signature of the service provider, DSPD, and the State Medicaid Agency. The effective date of the contract is the date the document is signed by all three parties.

DHS/DSPD requires submission of all mandatory State Audit requirements imposed on contracted providers by the State Auditor's Office. This information is a requirement of the contract entered into by DSPD and the provider.

Each year the DSPD Fiscal Review and Audit Unit reviews a sample of payment histories and the documentation to support those payments. This ensures the services were received and the correct payment was made. The sample includes information on all the contracted providers as well as recipient records.

Upon enrollment into the waiver the individual is informed of their responsibility and sign a letter of agreement to monitor and manage all employee(s) hours and wages. They are required to receive, sign and copy all employee(s) timesheets and submit them to the FMS agent twice a month. The participant is responsible to verify the accuracy of all hours billed by the employee(s).

Each month the administrative case manager reviews the billing statement and a monthly budget report generated by the DSPD Financial Analyst.

INTERAGENCY AGREEMENT FOR OPERATIONS AND ADMINISTRATION OF THE HCBS WAIVER

An interagency agreement between the State Medicaid Agency and DSPD sets forth the respective responsibilities for the administration and operation of this waiver. The agreement delineates the State Medicaid Agency's overall responsibility to provide management and oversight of the waiver including review and approval of all waiver related rules and policies to ensure compliance with Medicaid HCBS Waiver rules and regulations. The agreement also delineates DSPD's roles in relation to the statutory responsibilities to develop the State's program for persons with disabilities. The nature of the agreement enhances provider access to the Medicaid program and quality assurance of services as well as defines the fiscal relationship between the two agencies.

The major components of the agreement are:

1. Purpose and Scope;
2. Authority;
3. Definitions;
4. Waiver Program Administration and Operation Responsibilities;
5. Claims Processing;
6. Payment for Delegated Administrative Duties (including provisions for State match transfer);
7. Role Accountability and FFP Disallowances; and

8. Coordination of DHS Policy Development as it Relates to Implementation of the Medicaid Program.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

There are four principal methods used in setting the DHS Maximum Allowable Rate level. Each method is designed to determine a fair market rate. Because DHS provides services using various funding sources, including Title XIX, Title XX, Title IV-E among others, adjustments to the following processes may be deemed necessary on occasion to comply with funding requirements. Additionally, the process may be adjusted on occasion to account for common factors such as the geographical location of service delivery, absentee factors, or division budget constraints, etc.

1. Existing Market Survey or Cost Survey of Current Providers.

   This methodology surveys existing providers to determine their actual cost to render a service. This would include direct labor, supervision, administration, non-labor costs allocated to the purchased service and the basis of cost allocations. The surveys are designed to assure all providers are reporting costs in a standardized manner and within allowable costs parameters established by DHS. Surveys are examined to determine if cost definitions, allocations and reporting are consistent among respondents and accurately include reasonable costs of business. The rate is set using a measure of central tendency such as median, mode or weighted average and adjusted if necessary to reflect prevailing market conditions. (For example, a large provider may distort data and smaller providers may have substantially different costs. Failure to adjust for market realities may result in lack of available providers if the rate is set too low, or unnecessarily paying too much if the rate is set too high.)

2. Component Cost Analysis

   The estimated cost of each of the various components of a service code (rent, treatment, administration, direct labor, non-labor costs allocated to the service, etc) are determined and added together to determine a provisional rate. This method is often used for a new or substantially modified service that does not currently exist in the market place. Provisional rates are designed to determine a fair market rate until historical data becomes available. At a later date when historical cost data does become available a market survey may be undertaken to confirm or adjust the rate.

3. Comparative Analysis

This method may be used when a similar service exists. Adjustments are made to reflect any differences in the new service. Where possible and to provide consistency of payments in the provider community, rates are set to maintain common rates for common services purchased by various agencies. If a proposed service duplicates an existing service being used by another agency or program, the existing rate may be used to provide consistency of payments in the provider community, if the companion agency rate is considered to be in line with the market.

4. Community Price Survey

Where a broad based market exists for a service outside of DHS, existing service providers may be surveyed to determine the prevailing market price for the service. Again, measures of central tendency such as median, mode or weighted average are used and adjusted if necessary to reflect prevailing market.

b. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Requests for payments from the contracted providers are submitted to the Dept of Human Services/DSPD on form 520; payments are then made to the providers. Dept of Human Services/DSPD submits billing claims to DOH for reimbursement.

For individuals self-directing their personal attendant(s), the participant submits their staff time sheet(s) to the FMS Agent. The FMS Agent pays the claim(s) and submits a bill to DHS/DSPD on form 520. DHS/DSPD pays the FMS Agent then submits billing claim to DOH for reimbursement.

c. Certifying Public Expenditures *(select one)*:

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):
☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)

	☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
✓		**No**. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

DESCRIPTION OF BILLING PROCESS AND RECORDS RETENTION

1. A participant's Medicaid eligibility is determined by the Office of Health and Eligibility within the Department of Workforce Services or the Bureau of Eligibility Services within the Department of Health. The information is entered into the Public Assistance Case Management Information System (PACMIS). PACMIS is an on-line, menu-driven system which automates Medicaid eligibility decisions, benefits amounts, participants' notices and administrative reports. PACMIS interfaces with other governmental agencies such as, Social Security, Employment Security, and the Internal Revenue Service. The system is a Federally-Approved Management Information System (FAMIS). In Utah, the following programs are accessed through PACMIS: Aid to Families with Dependent Children (AFDC), Medicaid, Food Stamps, and two state-administered programs - General Assistance and the Primary Care Network (PCN). The Medicaid Management Information System (MMIS) accesses PACMIS to ensure the participant is Medicaid eligible before payment of claims is made.

2. Post-payment reviews are conducted by the Medicaid agency; reviews of a sample of individual written support plans and Medicaid claims histories to ensure: (1) all of the services required by the individual are identified in the support plan, (2) that the individual is receiving the services identified in the support plan, and (3) that Medicaid reimbursement is not claimed for waiver services which were not included in the support plan.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

✓	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
○	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
○	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

✓	The Medicaid agency makes payments directly to providers of waiver services.
☐	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
☐	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:
☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

✓	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

✓	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
○	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

✓	The amount paid to public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

✓	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

○	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
✓	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

○	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
✓	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
✓	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

✓	**Appropriation of State Tax Revenues to the State Medicaid agency**
☐	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
✓	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
✓	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

✓	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
○	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
✓	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

✓	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

✓	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:							
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$16,879	$16,972	$33,851	$25,149	$11,524	$36,673	$2,822
2	$17,195	$17,311	$34,506	$25,652	$11,755	$37,407	$2,901
3	$17,512	$17,658	$35,170	$26,165	$11,990	$38,155	$2,985
4	$17,888	$18,011	$35,899	$26,688	$12,230	$38,918	$3,019
5	$18,265	$18,371	$36,636	$27,222	$12,474	$39,696	$3,060

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	150		
Year 2	150		
Year 3	150		
Year 4 (renewal only)	150		
Year 5 (renewal only)	150		

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

Average Length of Stay (LOS) = 346 days
- Used the average annual LOS % increase for past 4 years (2002 – 2005) ~ 5.5%
- Multiplied the FY2005 actual LOS (328) by the average annual increase (5.5%)
- 328*1.055 = ~ 346 days

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

- All calculations are based off the actual amounts for FY2005
- Client Count for FY2005 was 112 and the new unduplicated# is 150 (an increase of ~ 34%), so all other Client Counts were raised by the same rate and rounded to the next whole number
- Financial Management Services client counts were calculated by allocating 80% to low level and 20% to high level
- Price per unit was increased 4% for the first year (to account for FY2006), and each subsequent year was increased 2%
- Units Per User is the average units per user for FY2005 rounded to the next whole number

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- All calculations are based off the actual amounts for FY2005
- Average cost per enrollee was increased by 4% for the first year (to account for FY2006), and each subsequent year was increased 2%

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- All calculations are based off the actual amounts for FY2005
- Average cost per enrollee was increased by 4% for the first year (to account for GY2006), and each subsequent year was increased 2%

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

- All calculations are based off the actual amounts for FY2005
- Average cost per enrollee was increased by 4% for the first year (to account for GY2006), and each subsequent year was increased 2%

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

✓	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

i. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Care Training to Client - Per 15 Min	15 Min	15	5	$5.29	$397
Emergency Response System – Purchase	Each	20	1	$225.91	$4,518
Emergency Response System – Per Month	Monthly	67	11	$34.27	$25,257
Supports Brokerage, Self-Directed – Per 15 Min	15 Min	109	32	$12.05	$42,030
Attendant Care Services – Per 15 Min	15 Min	150	5929	$2.68	$2,383,458
Financial Management Services, Low – Per Month	Monthly	120	12	$28.69	$41,314
Financial Management Services, High – Per Month	Monthly	30	12	$93.94	$33,818
Personal Emergency Response Systems, Installation & Testing	Each	20	1	$50.00	$1,000
GRAND TOTAL:					$2,531,792
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					150
FACTOR D (Divide total by number of participants)					$16,879
AVERAGE LENGTH OF STAY ON THE WAIVER					346

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Care Training to Client - Per 15 Min	15 Min	15	5	$5.40	$405
Emergency Response System – Purchase	Each	20	1	$230.43	$4,609
Emergency Response System – Per Month	Monthly	67	11	$34.96	$25,766
Supports Brokerage, Self-Directed – Per 15 Min	15 Min	109	32	$12.29	$42,868
Attendant Care Services – Per 15 Min	15 Min	150	5929	$2.73	$2,427,926
Financial Management Services, Low – Per Month	Monthly	120	12	$29.26	$42,134
Financial Management Services, High – Per Month	Monthly	30	12	$95.82	$34,495
Personal Emergency Response Systems, Installation & Testing	Each	20	1	$51.00	$1,020
GRAND TOTAL:					$2,579,223
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					150
FACTOR D (Divide total by number of participants)					$17,195
AVERAGE LENGTH OF STAY ON THE WAIVER					346

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Care Training to Client - Per 15 Min	15 Min	15	5	$5.51	$413
Emergency Response System – Purchase	Each	20	1	$235.04	$4,701
Emergency Response System – Per Month	Monthly	67	11	$35.66	$26,281
Supports Brokerage, Self-Directed – Per 15 Min	15 Min	109	32	$12.54	$43,740
Attendant Care Services – Per 15 Min	15 Min	150	5929	$2.78	$2,472,393
Financial Management Services, Low – Per Month	Monthly	120	12	$29.85	$42,984
Financial Management Services, High – Per Month	Monthly	30	12	$97.74	$35,186
Personal Emergency Response Systems, Installation & Testing	Each	20	1	$52.02	$1,040
GRAND TOTAL:					$2,626,738
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					150
FACTOR D (Divide total by number of participants)					$17,512
AVERAGE LENGTH OF STAY ON THE WAIVER					346

Waiver Year: Year 4 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Care Training to Client - Per 15 Min	15 Min	15	5	$5.62	$422
Emergency Response System – Purchase	Each	20	1	$239.74	$4,795
Emergency Response System – Per Month	Monthly	67	11	$36.37	$26,805
Supports Brokerage, Self-Directed – Per 15 Min	15 Min	109	32	$12.79	$44,612
Attendant Care Services – Per 15 Min	15 Min	150	5929	$2.84	$2,525,754
Financial Management Services, Low – Per Month	Monthly	120	12	$30.45	$43,848
Financial Management Services, High – Per Month	Monthly	30	12	$99.69	$35,888
Personal Emergency Response Systems, Installation & Testing	Each	20	1	$53.06	$1,061
GRAND TOTAL:					$2,683,185
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					150
FACTOR D (Divide total by number of participants)					$17,888
AVERAGE LENGTH OF STAY ON THE WAIVER					346

Waiver Year: Year 5 *(renewal only)*					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Home Care Training to Client - Per 15 Min	15 Min	15	5	$5.73	$430
Emergency Response System – Purchase	Each	20	1	$244.53	$4,891
Emergency Response System – Per Month	Monthly	67	11	$37.10	$27,343
Supports Brokerage, Self-Directed – Per 15 Min	15 Min	109	32	$13.05	$45,518
Attendant Care Services – Per 15 Min	15 Min	150	5929	$2.90	$2,579,115
Financial Management Services, Low – Per Month	Monthly	120	12	$31.06	$44,726
Financial Management Services, High – Per Month	Monthly	30	12	$101.68	$36,605
Personal Emergency Response Systems, Installation & Testing	Each	20	1	$54.12	$1,082
GRAND TOTAL:					$2,739,710
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					150
FACTOR D (Divide total by number of participants)					$18,265
AVERAGE LENGTH OF STAY ON THE WAIVER					346

ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers. Complete the following table for each waiver year.

Waiver Year: Year 1						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 2						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 3						
Waiver Service	Col. 1 **Check if included in capitation**	Col. 2 **Unit**	Col. 3 **# Users**	Col. 4 **Avg. Units Per User**	Col. 5 **Avg. Cost/ Unit**	Col. 6 **Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 4 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Waiver Year: Year 5 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	**Unit**	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
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GRAND TOTAL:						
Total: Services included in capitation						
Total: Services not included in capitation						
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						
FACTOR D (Divide grand total by number of participants)						
Services included in capitation						
Services not included in capitation						
AVERAGE LENGTH OF STAY ON THE WAIVER						

Request for Evidentiary-Based Information

Level of Care Determination

Evidence that:

- An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.
- Enrolled participants are reevaluated at least annually or as specified in its approved waiver.
- The process and instruments described in the approved waiver are applied to determine LOC.
- The state monitors level of care decisions and takes action to address inappropriate level of care determinations.

Examples:

Reports from state monitoring reviews conducted; a summary report of all reviews; minutes of committee meetings showing evaluation of findings and recommendations and strategies for improvement developed. Do not submit policies, procedures, forms or individual participant records.

Plan of Care

Evidence that:

- POCs address all participant's assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.
- The state monitors POC development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of POCs.
- POCs are updated/revised when warranted by changes in the waiver participant's needs
- Services are specified by type, amount, duration, scope and frequency and are delivered in accordance with the POC.
- Participants are afforded choice:
    1) between waiver services and institutional care
    2) between/among waivers services and providers

Examples:

Reports from state monitoring reviews of POCs; reports of monitoring of service refusal and analysis; reports of state monitoring (e.g., provider, county, case management) to verify that services in POC have been received; summary report of all reviews; minutes of committee meetings showing evaluation of findings, recommendations and corrective actions taken and strategies for improvement developed; results of feedback from participant interviews or focus groups; analysis of incident reports/complaints; analysis of reported incidents; results of focus group meetings; results of staff interviews. Do not submit policies, procedures, forms or individual participant records.

Qualified Providers

Evidence that:

- The state verifies, on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards.
- The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
- The state identifies and rectifies situations where providers do not meet requirements.
- The state implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.

Examples:

Reports from state monitoring; minutes of committee meetings showing evaluation of findings and recommendations related to provider qualifications and training; actions taken when deficiencies are identified such as sanctions or correspondence; reports include both licensed providers and those qualified through other means; analysis of complaints or incident reports; documentation of TA/training sessions. Do not submit policies, procedures, forms, qualification standards or provider records.

Health and Welfare

Evidence that:

- The state, on an ongoing basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation.

Examples:

Ongoing monitoring reports; reports and analysis of complaints; reports and analysis of allegations of abuse neglect and exploitation; results of investigations and actions taken; reports and action taken on plan of care discrepancies; minutes of QA or other committee meetings that show review of monitoring, recommended actions and follow-up reports. Do not submit policies, procedures, forms or individual participant records.

Administrative Authority

Evidence that:

- The Medicaid agency or operating agency conducts routine, ongoing oversight of the waiver program.

Examples:

A description of the state quality management program with evidence of activity such as monitoring and review reports; committee minutes; a record of actions taken; record of service denials and appeal requests; copies of issued notices of appeal.

Financial Accountability

Evidence that:

- State financial oversight exists to assure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.

Examples:

Audit reports; monitoring reports; management meeting minutes that reflect analysis, recommendations and actions.